2012 Update

**Equip Yourself With New Codes To Report Neurolysis in 2012**

Keep a count of joints, regardless of the numbers of nerves.

When reporting the paravertebral facet joint nerve injections in 2012, you will no longer be counting nerves that your surgeon targeted. You have so far been reporting injections for every nerve at a single vertebral level. Effective Jan. 1, you’ll need to adjust your method to look for the specific anatomical site involved and also the work that your surgeon did. Read on for more on what changes to expect for these injections in 2012: what goes obsolete and what new comes in.

**Know the Deletions**

Here are four codes that will be deleted in 2012:

- 64622 *(Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level)*
- +64623 *(Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level [List separately in addition to code for primary procedure]*)
- 64626 *(Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level)*
- +64627 *(Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level [List separately in addition to code for primary procedure]*)

**Look at New Codes**

You will find four new codes in 2012. These include the following:

- 64633 *(Destruction by neurolytic agent, paravertebral facet joint nerve[s], with imaging guidance [fluoroscopy or CT]; cervical or thoracic, single facet joint)*
- +64634 *(Destruction by neurolytic agent, paravertebral facet joint nerve [s], with imaging guidance [fluoroscopy or CT]; cervical or thoracic, each additional facet joint [List separately in addition to code for primary procedure]*)
- 64635 *(Destruction by neurolytic agent, paravertebral facet joint nerve[s], with imaging guidance [fluoroscopy or CT]; lumbar or sacral, single facet joint)*
- +64636 *(Destruction by neurolytic agent, paravertebral facet joint nerve[s], with imaging guidance [fluoroscopy or CT]; lumbar or sacral, each additional facet joint [List separately in addition to code for primary procedure]*)
Don’t Separately Report Image Guidance

When reporting neurolysis described by new codes 64633-64636, make sure your surgeon has used and documented the image guidance used to perform the paravertebral facet joint nerve destruction. The codes for 2012 are inclusive of the image guidance, so you do not independently report the fluoroscopy or CT guidance used for the paravertebral nerve localization. “Note that image guidance with either fluoroscopy or CT is both required and is bundled into the new codes,” says Gregory Przybyski, MD, director of neurosurgery, New Jersey Neuroscience Institute, JFK Medical Center, Edison.

Tip: You do not report 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures [epidural, subarachnoid, or sacroiliac joint], including neurolytic agent destruction) for fluoroscopic guidance and 77012 (Computed tomography guidance for needle placement [eg, biopsy, aspiration, injection, localization device], radiological supervision and interpretation) for CT guidance with 64633-64636.

Note: If your surgeon does the paravertebral facet joint injection without using the image guidance or does not adequately document the imaging guidance, you report an unlisted CPT® code 64634 (Unlisted procedure, nervous system).

Report Bilateral Injections: If your surgeon treats both the facet joints at the same vertebral level, you will need to confirm with your payer for reporting the bilateral procedure. According to payer preferences, you may append 50 (Bilateral Procedure) or use RT/LT or use units.

Editor’s note: See future issues of Neurosurgery Coding Alert for more analysis of how the 2012 coding updates will affect your coding and billing.

Coding Strategies

Heed These Spinal Instrumentation Coding Steps To Recoup All Deserved Pay

Approach, span and devices influence your claim

When your neurosurgeon provides spinal instrumentation services, you’ll need to identify what instruments were used and whether the surgeon removed and reinserted the instrumentation. Brush up on your spinal instrumentation coding skills — and improve your claim results for these services — by following our expert advice:

Identify the Device

When your surgeon places wires, screws, rods, or any other spinal fixation, you can efficiently select the appropriate code if you know the approach and fixation points.
There are ten codes you can choose from when you report initial spinal instrumentation:

+ **22840** — Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxialtransarticular screw fixation, sublaminar wiring at C1, facet screw fixation) [List separately in addition to code for primary procedure]

+ **22841** — Internal spinal fixation by wiring of spinous processes [List separately in addition to code for primary procedure]

+ **22842** — Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments [List separately in addition to code for primary procedure]

+ **22843** — Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments [List separately in addition to code for primary procedure]

+ **22844** — Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments [List separately in addition to code for primary procedure]

+ **22845** — Anterior instrumentation; 2 to 3 vertebral segments [List separately in addition to code for primary procedure]

+ **22846** — Anterior instrumentation; 4 to 7 vertebral segments [List separately in addition to code for primary procedure]

+ **22847** — Anterior instrumentation; 8 or more vertebral segments [List separately in addition to code for primary procedure]

+ **22848** — Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum [List separately in addition to code for primary procedure]

+ **22851** — Application of intervertebral biomechanical device(s) (e.g., synthetic cage[s], methylmethacrylate) to vertebral defect or interspace. [List separately in addition to code for primary procedure]

**Determine the Approach**

You’ll be well on the way to appropriate coding if you can determine from the op note whether the neurosurgeon used an anterior or posterior approach for the instrumentation.

You select from codes 22840, 22841, 22842, 22843, 22844 and 22848 for a posterior approach and 22845, 22846, and 22847 for an anterior approach for the spinal instrumentation. Documenting the approach (anterior, posterior, direct lateral, extreme lateral) is something that spine surgeons do almost unfailingly,” says Heidi Stout, BA, CPC, COSC, PCS, CCS-P, Coder on Call, Inc., Milltown, New Jersey and orthopedic coding division director, The Coding Network, LLC, Beverly Hills, CA.

**Don’t miss:** “An intervertebral biomechanical device, reported with 22851, can be placed either through an anterior or posterior approach. Code 22848 is used to describe pelvic fixation separate from sacral fixation, and is typically used in addition to a posterior segmental fixation code,” advises Gregory Przybyski, MD, director of neurosurgery, New Jersey Neuroscience Institute, JFK Medical Center, Edison.

**Count Fixation Points in Posterior Approach**

Once you confirm the posterior approach, the next step is to determine if the device is segmental (22842-22844) or non-segmental (22840). For this portion, you count the number of fixation points.

Irrespective of the span, if the instrumentation is attached to only two vertebral segments, you consider the instrumentation to be non-segmental and report code 22840. If, however, the instrumentation is affixed to three or more vertebral segments, you select from codes 22842 to 22844.
the instrumentation is considered segmental. “Although spine surgeons apply the biomechanical definition of segmental fixation to L4-5 pedicle screw fixation, CPT® defines this as non-segmental fixation since instrumentation only attaches to two segments,” says Przybylski.

“In order for instrumentation to be considered segmental, there must be a proximal fixation point and a distal fixation point with at least one intervening fixation point,” confirms Stout. “A pedicle screw construct that runs from L2 to S1 with screws placed at all intervening levels constitutes 5 segment instrumentation and is reported with code 22842. On the other hand, if a rod and screw construct spans L2 to S1 but no screws are placed at any intervening level, this is non-segmental fixation and is reported with code 22840,” she adds.

**Confirm Removal of Vertebral Portions**

Your surgeon may remove a vertebra (i.e. corpectomy) or may remove an intervertebral disc. If the surgeon uses a metal cage or other prosthetic device to fill the defect in order to stabilize the area, you specifically report this as code 22851.

**Remember:** When reporting 22851, you count the number of spinal defects treated, not the number of devices placed within a single defect. If the surgeon uses multiple devices at one defect, you report only a single unit of 22851. If, however, the surgeon places devices at more than one spinal defect, you report one unit of 22851 for each individual spinal defect treated. The additional units would be appended with modifier -59 (Distinct procedural service) to signify the separate anatomical sites.

**Example:** If your surgeon places two cages at T4-T5, you report one unit of 22851. However, if your surgeon places one cage at T3-T4 and two cages at level T5-T6, you report 22851 and 22851-59.

**Distinguish Instrumentation Removal**

There are different codes you may choose from when your surgeon is removing spinal instrumentation. You can report the instrumentation removal if the surgeon removes the instrumentation for damage, failure or other complications. If, however, the surgeon does the removal to explore the spinal fusion, you cannot report the instrumentation removal in addition to the exploration of fusion.

You select from the following codes when reporting the instrumentation removal:

- **22850 — Removal of posterior nonsegmental instrumentation (e.g., Harrington rod)**
- **22852 — Removal of posterior segmental instrumentation**
- **22855 — Removal of anterior instrumentation.**

**Furthermore:** Note that the instrumentation codes are stand-alone codes and are subject to the -51 multiple procedure modifier reduction. In addition, code 22855 can be shared among co-surgeons, such as when an approach surgeon exposes the anterior thoracolumbar spine so that the spine surgeon can safely remove anterior spinal instrumentation.

**Report Reinsertions**

Your surgeon in some instances like a revision of a prior fusion for pseudoarthrosis may reinsert the instrumentation after the procedure is complete; in this case, you would report 22849 (Reinsertion of spinal fixation device). This instrumentation code is also a stand-alone code subject to the -51 multiple procedure modifier reduction.

**Be Careful with Modifiers**

Confirm with your payer which modifiers are approved for spinal instrumentation services, as not all may be accepted. Some will permit modifier -59 (Distinct procedural service) to the ‘additional’ unit(s) to demonstrate that the surgeon did the instrumentation at separate anatomic location(s). “Since most of the instrumentation codes are add-on codes, those are most subject to the -51 modifier. Both the anterior instrumentation removal 22855 and revision of instrumentation code 22494 both accept the -62 co-surgery modifier,” says Przybylski.

**Example:** If your surgeon places one cage at T3-T4 and two cages at level T5-T6, you report 22851 x 2 and append modifier -59 depending upon your payer. “In this scenario, CPT® advises reporting the cages placed at different spinal interspaces as two line items, 22851 and 22851-59,” says Stout.

Spinal instrumentation codes (22840-22848 and 22851) are modifier -51 (Multiple procedures) exempt, so you would not report -51 with any of these. Carefully study the operative note to determine where the surgeon places the instrumentation.

**Example:** If you read that the surgeon performed arthrodesis at interspaces C6-7, C7-T1 and T1-T2 and placed anterior instrumentation attached at C6 and T2, you report 22846 for the instrumentation for the four segments C6 to T2. “You also report the appropriate codes for arthrodesis for each level. These are 22554 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace [other than for decompression]; cervical below C2) and +22585 (… each additional interspace [list separately in addition to code for primary procedure]) for C7-T1 and T1-T2 interspaces. Code
22554 applies as the initial level arthrodesis since the surgical approach in this circumstance would be an extended anterior cervical approach,” says Przybylski. “When an arthrodesis crosses spinal regions (in this case from cervical to thoracic), only one primary arthrodesis code can be reported. In this case, you would report 22554 and +22585, +22585-59. Also report the code for the type of interbody device and/or graft material that was used. If a separate anterior plate is applied from C6 to T2, report code 22846,” says Stout.

When your surgeon is removing the instrumentation in the global period because an infection necessitated the return of the patient to the operating room for the removal, you append modifier -78 (Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period) to the appropriate spinal instrumentation removal code. “Codes for spinal instrumentation removal are 22855, 22850, and 22852,” says Stout.

**ICD-10 Update**

**Let Specific Regions Guide Your Radiculopathy Dx**

Single ICD-9 code expands to four codes in ICD-10.

Radiculopathy gets site-specific for spinal regions in ICD-10. To ensure that your surgeon will be ready when the Oct. 1, 2013 deadline hits, you can reinforce the need for specific region in the operative note in the documentation. Make sure your surgeon mentions the involvement of one or more cervical, thoracic, lumbar or sacral regions.

**Review Anatomical Locations**

The spine is divided into five regions, namely the cervical, thoracic, lumbar, sacral, and coccygeal regions (Figure 1). There are 33 vertebrae that encase the spinal cord. These include the 7 cervical (C1-C7), 12 thoracic (T1-T12), 5 lumbar (L1-L5), 5 sacral (S1-S5), and 4 coccygeal bones. The last two regions are fused together and the rest are separated by intervertebral spaces. The coccyx is also called the tail bone. The nerves emerge from the intervertebral foramina and the initial segment of the nerves close to the site of their origin from the spinal cord is called ‘nerve root’. There are 31 pairs of spinal nerve roots.

One or more nerves may be inflamed, compressed, or may suffer a compromise in blood supply. This leads to neuropathy in one or more segments called radiculopathy. This may result in pain in the region that is supplied by the individual nerves.

When you report the code(s) for the radiculopathy, the anatomical localization of the neuritis is your best guide. “For example, upper limb pain may represent cervical radiculitis, whereas lower limb pain may represent lumbar radiculitis,” says Gregory Przybylski, MD, director of neurosurgery, New Jersey Neuroscience Institute, JFK Medical Center, Edison.

The regions may overlap, though the nerve roots are discrete. You may often come across a numerical representation in your surgeon’s notes. For example, your surgeon may report the involvement of the nerve roots at the junction of the last lumbar and first sacral region as L5-S1. In this case, you would report the lumbosacral regional involvement.

When your surgeon is removing the instrumentation in the global period because an infection necessitated the return of the patient to the operating room for the removal, you append modifier -78 (Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period) to the appropriate spinal instrumentation removal code. “Codes for spinal instrumentation removal are 22855, 22850, and 22852,” says Stout.

**You Be the Coder**

**Use Discrete Codes for Decompression and Arthrodesis in Cervical Region**

**Question:**
In a patient diagnosed with ‘platybasia with occipitocervical instability’, our surgeon did the following procedure:

“Occipito-cervical fusion (pedicle screws and rods) - occiput to C2, C3, C4 with laminectomy C2, C3, C4, posterior foramen magnum resection, decompression of brainstem and spine at the cranio cervical junction.”

What are the correct codes we can report?

**Answer:** See page 87. California Subscriber

(Continued on next page)
Get Familiar With 4 Specific Codes

In ICD-9, the codes that you use to report radiculitis are 723.4 (Brachial neuritis or radiculitis) and 724.4 (Thoracic or lumbosacral neuritis or radiculitis, unspecified). This sole code covers the radiculopathy in the thoracic, lumbar, and sacral regions. In ICD-10, there are four codes that are used for the specific involved region. These are as follows:

- M54.14 (Radiculopathy, thoracic region)
- M54.15 (Radiculopathy, thoracolumbar region)
- M54.16 (Radiculopathy, lumbar region)
- M54.17 (Radiculopathy, lumbosacral region)

Remember: Code 724.2 (Lumbago) refers to lumbago or low back pain. You should never have that overlap with M54.17. Though radiculopathy in the lumbosacral region can have a component of low back pain, it is important that you determine the cause of the low back pain. Low back pain has a myriad of possible causes like degeneration of spine, compression due to lesions like a cancerous growth, fracture, muscular strain and many more. “In addition, lumbago as a code cannot be used for surgical procedures as insurance companies will deny payment for that diagnosis,” says Bill Mallon, MD, medical director, Triangle Orthopedic Associates, Durham, N.C.

Reader Questions

Use Specific Codes for Burst Fractures

Question:
How do we report T11 and T12 laminectomies done to decompress the spinal cord from retropulsed bone fragments from T12 burst fracture. The fragments were not removed nor was there a fusion.

Answer:
Unless a facetectomy was performed to gain more lateral exposure, you report this as 63003 (Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy [eg, spinal stenosis], 1 or 2 vertebral segments; thoracic).

Arizona Subscriber

Look for Procedures Inclusive in Corpectomy

Question:
Through anterior approach to the lumbar spine at L3 to S1, our surgeon did diskitomy L3-S1, bilateral foraminotomies L3-S1, partial corpectomies L3-S1, interbody arthrodesis with implantation of peek cage and morselized allograft L3-S1, and arthrodesis with titanium screws L3-S1.

How do we report this procedure? Can we bill the corpectomy as it basically done to prepare space for implantation of cage?

Answer:
When you refer to corpectomy as preparing the space for implantation of the cage, it is unlikely that more than one third of the vertebral body was removed, precluding use of the corpectomy codes 63090 (Vertebral corpectomy [vertebral body resection], partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root[s], lower thoracic, lumbar, or sacral; single segment) and 63091 (Vertebral corpectomy [vertebral body resection], partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root[s], lower thoracic, lumbar, or sacral; each additional segment [List separately in addition to code for primary procedure]).

You report the arthrodesis with 22558 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace [other than for decompression]; lumbar) for

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Do Not Forget the Assistant Services

Question:
Our surgeon placed an epidural drug infusion pump. An assistant helped in this procedure. Postoperatively, the patient was moved out of the OR and the assistant then performed the electronic analysis. Is it correct to bill both 62362-AS and 62368 for the surgeon assistant? Or, is the code 62368 already included in the 62362 portion of the procedure performed that same day?

Answer:
You report 62362 (Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming). The initial interrogation and programming is included in the vignette for placement of the infusion pump. Subsequent electronic analysis and reprogramming may be reported with 62368 (Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion [includes evaluation of reservoir status, alarm status, drug prescription status]; with reprogramming), appended with the appropriate modifier if needed.

New York Subscriber

Remember: Code 724.2 (Lumbago) refers to lumbago or low back pain. You should never have that overlap with M54.17. Though radiculopathy in the lumbosacral region can have a component of low back pain, it is important that you determine the cause of the low back pain. Low back pain has a myriad of possible causes like degeneration of spine, compression due to lesions like a cancerous growth, fracture, muscular strain and many more. “In addition, lumbago as a code cannot be used for surgical procedures as insurance companies will deny payment for that diagnosis,” says Bill Mallon, MD, medical director, Triangle Orthopedic Associates, Durham, N.C.
the L3-L4 arthrodesis. You select code 22585 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace [other than for decompression]; each additional interspace [List separately in addition to code for primary procedure]) x 2 for arthrodesis at L4-L5 and L5-S1. These codes include discectomy and bony removal required for placement of an interbody material including cage implantation. If a separately identifiable nerve decompression with foraminotomy was medically-necessary and performed, this would be reported with an unlisted code 64999.

The CPT® codes for corpectomy include discectomy, excision of osteophytes, and use of magnification or loupes. Arthrodesis, instrumentation, placement of halo, and harvesting and insertion of bone graft are excluded in corpectomy codes. You should be careful in reading the procedure as surgeons often drill adjacent upper and lower endplates to remove posterior osteophytes and to improve visualization and access. For instrumentation, you report 22846 (Anterior instrumentation; 4 to 7 vertebral segments [List separately in addition to code for primary procedure]) and for graft you report 20030 (Allograft, morselized, for spine surgery only [List separately in addition to code for primary procedure]) and 22851 (Application of intervertebral biomechanical device[s] [eg. synthetic cage[s], methylmethacrylate] to vertebral defect or interspace [List separately in addition to code for primary procedure]) for each interspace that a PEEK cage was placed.

**Code for Tumor in Skull Osteoma**

**Question:**
How do we code for a resection of a skull osteoma?

**Georgia Subscriber**

**Answer:**
You report resection of skull osteoma with code 61500 (Craniectomy; with excision of tumor or other bone lesion of skull).

**Do Not Duplicate Botox Injections**

**Question:**
On the same day, our surgeon injected Botox into the forehead for migraine headaches and into the neck for dystonia. Can we bill both codes adding a 59 modifier to one?

**Wisconsin Subscriber**

**Answer:**
Yes. You could bill both codes on the same day without appending modifier -59 (Distinct procedural service). Botox for the treatment of migraines must be billed as one service/day (injection) and it can be billed with 64612 (Chemodenervation of muscle[s]; muscle[s] innervated by facial nerve [eg, for blepharospasm, hemifacial spasm]) and for the neck, it can be billed with 64613 (Chemodenervation of muscle[s]; neck muscle[s] [eg, for spasmatic torticollis, spasmodic dysphonia]). Here modifier -59 is not required to bill it on the same day because CCI does not bundle these two codes together. Many Medicare contractors have requested that providers not append modifier 51 (Multiple procedures) to services because their computerized claims processing software will automatically append the modifier to the code(s) with the lower relative value units (RVUs). Private payers may want you to append modifier -51 to the lower-valued code i.e. 64613.

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**You Be the Coder**

**Use Discrete Codes for Decompression and Arthrodesis in Cervical Region**

**(Question on page 85)**

**Answer:**
You report the resection of the posterior foramen magnum and decompression of brainstem and spine with 61343 (Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft [eg, Arnold-Chiari malformation]). Also include codes 22590 (Arthrodesis, posterior technique, craniocervical [occiput-C2]) for the occipitocervical fusion from the occiput to C2, 22600 (Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment) -51 (Multiple procedures) for C2-3 and 22614 (Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment [List separately in addition to code for primary procedure]) for C3-4. You report the posterior instrumentation with the segmental posterior instrumentation code 22842 (Posterior segmental instrumentation [eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires] 3 to 6 vertebral segments [List separately in addition to code for primary procedure]). You may report bone graft harvest and spinal navigation separately, if performed.
Neurosurger y
CODING ALERT

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to Neurosurgery coding and reimbursement to the Editor indicated below.

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